BODY ELEMENTS CHIROPRACTIC AT ENCORE
believe in better!
believe you deserve it!
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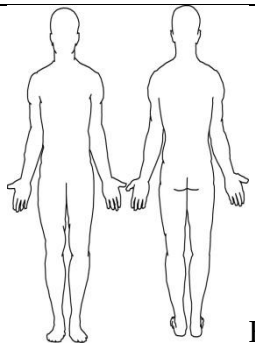
Minor Intake

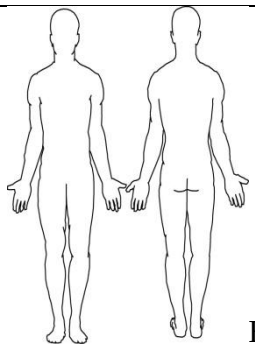
Name: Date of Birth: Today's Date:

Chief complaint information- Room for only two, if there is more, we'll go in to more details

Primary chief complaint

Complaint / issue?	Have you experience this before? ☐ Yes ☐ No
How did it start?	When did it start?
What makes it worse?	What makes it better?
Have you seen anyone else for this? ☐ Yes ☐ No	If yes, who? _____
Any radiation of symptoms? ☐ Yes ☐ No	If yes, to where? _____
Is it: ☐Achy ☐Sharp ☐Numb / Tingling ☐Deep	Please mark the location below:
Have you tried: ☐Hot ☐Cold ☐ Meds _____ ☐ Other: _____	 Front Back
Your symptoms effected when you; ☐Sit ☐ Sleep ☐Walk ☐Standup ☐Bend ☐ Movement ☐ Other: _____	
How often? ☐ Daily ☐Weekly ☐ Monthly ☐ Constant	
Do you consider this to be serious? ☐ Yes ☐ No	

Secondary chief complaint

Complaint / issue?	Have you experience this before? ☐ Yes ☐ No
How did it start?	When did it start?
What makes it worse?	What makes it better?
Have you seen anyone else for this? ☐ Yes ☐ No	If yes, who? _____
Any radiation of symptoms? ☐ Yes ☐ No	If yes, to where? _____
Is it: ☐Achy ☐Sharp ☐Numb / Tingling ☐Deep	Please mark the location below:
Have you tried: ☐Hot ☐Cold ☐ Meds _____ ☐ Other: _____	 Front Back
Your symptoms effected when you; ☐Sit ☐ Sleep ☐Walk ☐Standup ☐Bend ☐ Movement ☐ Other: _____	
How often? ☐ Daily ☐Weekly ☐ Monthly ☐ Constant	
Do you consider this to be serious? ☐ Yes ☐ No	

Infant history

Complications during pregnancy? ☐Yes ☐No	If yes, what?
Medication use while pregnant? ☐Yes ☐No	If yes, list here:
Cigarette/Alcohol use while pregnant? ☐Yes ☐No	Ultrasound during pregnancy? ☐Yes ☐No
Birth method: ☐ Vaginal ☐C-Section	If C-section was it: ☐Emergency ☐Planned
Birth location: ☐ Home ☐Birthing center ☐Hospital ☐Other: _____	
Interventions used: ☐ None ☐Water ☐Forceps ☐Vacuum extraction ☐Other: _____	
Birth Weight: Birth Length: APGAR Scores:	
Was the child; ☐ Term ☐ Pre-term	Did the baby cry at birth? ☐Yes ☐No
Complications during delivery? ☐Yes ☐No	If yes, what?
Genetic disorders or disabilities ☐Yes ☐No	If yes, what?
Breast fed? ☐Yes ☐No	If yes, how long?
Formula fed? ☐Yes ☐No	If yes, how long?
Introduced to cow's milk at: _____ months	Introduced to solids at: _____ months
Food allergies / intolerance? ☐Yes ☐No	If yes, to what?
How was your child's heath at birth? (* more than one answer is possible)	
☐ Normal ☐ Injured at birth ☐ Difficulty breathing ☐ Problems with heart ☐ Jaundice ☐ Infection	
☐ Low birth weight ☐ Problems with bones ☐ Fever or seizures ☐ Required blood transfusion	
☐ Placed in intensive care ☐ Other _____	

Lifestyle questions – **You may be brief we'll go into more details if necessary.**

Has your child been on any medication for a prolonged amount of time? ☐Yes ☐No			
If yes, what, why and for how long?			
Is your child currently taking medication(s)? ☐Yes ☐No			
If yes, what and for what purpose?			
Do you take: ☐Vitamin D?	☐Probiotics?	☐Fish oil?	☐Multivitamin?
List any other supplements if any:			
Has he/she ever been hospitalized? ☐Yes ☐No	If yes, why?		
Has he/she ever had any surgeries? ☐Yes ☐No	If yes where on the body and why?		

Has he/she had major accidents / falls? ☐Yes ☐No	If yes, please explain.
Does/did he/she have any fractures? ☐Yes ☐No	If yes, where?
Does he/she have any scars? ☐Yes ☐No	If yes, where?
Does he/she have any Mercury fillings? ☐Yes ☐No	Does he/she have any root canals? ☐Yes ☐No

What describes your child's temperament?

☐ Don't know	☐ Difficult	☐ Calm	☐ Irritable	☐ Active	☐ Hyper-sensitive
☐ Sociable	☐ Angry	☐ Withdrawn	☐ Regular mood	☐ Irregular mood	☐ Other
☐ Happy	☐ Sad	☐ Alert	☐ Easily scared	☐ Cranky	☐ Sleepy
☐ Curious	☐ Affectionate	☐ Playful	☐ Frequent crying	☐ Other: _____	

Is he/she vegetarian? ☐Yes ☐No	Is he/she vegan? ☐Yes ☐No

How often does he/she consume;

- Fruit? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Vegetables? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Protein? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Dairy? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day
- Soda? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day

How often does he/she exercise? ☐Never ☐Once in a while ☐Weekly ☐ Daily ☐Multiple times per day

Commitment to your child's health? ☐Not at all ☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ Extremely

Importance of your child's health to you? ☐Not at all ☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ Extremely

Do you think your child's health is: ☐Challenged ☐Fair ☐Good ☐Very Good ☐Excellent

Would you like your child's health to be: ☐Challenged ☐Fair ☐Good ☐Very Good ☐Excellent

Circle P for previously and / or C for current if / where applicable					
P	C	Headaches / Migraines	P	C	Nervousness / Panic attacks
P	C	Insomnia: All the time/ Frequent/ Occasional	P	C	Chronic Tiredness
P	C	Dizziness / Light Headedness	P	C	Amnesia
P	C	Sinus Trouble	P	C	Allergies If so, to what?
P	C	Earaches / Infection Left / Right	P	C	Vision Problems and or Ear Problems
P	C	Stiff Neck	P	C	Acne / Pimples / Eczema / Psoriasis
P	C	ADD / ADHD / OCD / Learning disorder	P	C	Immune System Challenges
P	C	Difficulty Breathing / Lung Condition	P	C	Asthma

Circle P for previously and / or C for current if / where applicable					
P	C	Nausea / Vomiting Frequent / Occasional	P	C	Heart Condition / Palpitations / Surgeries
P	C	Colic	P	C	Frequent Flu / Cough / Colds
P	C	Gallbladder Condition / Removed / When?	P	C	Cancer
P	C	Liver Condition / Jaundice	P	C	Diabetes Type I / Type II / Insulin?
P	C	Slow to Heal from Cuts	P	C	Shoulder Pain Left / Right
P	C	Kidney Challenges / Stones	P	C	Grinding Teeth at Night
P	C	Scoliosis; Neck / Upper back / Lower back	P	C	Gas Challenges
P	C	TMJ issues Left / Right	P	C	Constipation / Diarrhea
P	C	Knee Pain Left / Right	P	C	PMS – Emotional / Mood Swings
P	C	Swollen Ankles Left / Right	P	C	Menstrual Cramps / Irregularity
P	C	Weak Ankles Left / Right	P	C	Leg Cramps: Daily / Weekly / Monthly
P	C	Depression	P	C	Sore throat
P	C	Bed wetting	P	C	Bronchitis
P	C	Other:	P	C	Other:

Circle M for child's mother and / or F for child's father where / if applicable.					
F	M	Diabetes	F	M	Heart Disease
F	M	High Blood pressure	F	M	Rheumatoid Arthritis
F	M	Lupus	F	M	Cancer
F	M	Other:	F	M	Other:

Notes: _____

Previous Chiropractic experience
Has your child ever been under Chiropractic care before? ☐Yes ☐No
If yes, what was the reason for his/her visit?
His/her previous experience was; ☐ Excellent ☐Good ☐Beneficial ☐Bad Other: _____
When was his/her last physical?
When was his/her last X-ray?
Positive findings?

What goals would you like to achieve while under care in this office?
Is there anything else you would like to comment on today?

Your purpose today for visiting this office today is: ☐ Temporary pain reduction ☐BEST ☐Corrective care ☐Wellness care ☐Nutrition Response Therapy ☐ADD/ ADHD ☐Other:_____

Signature and name of guardian:_____ Date: _____

Your health is your greatest asset. Thank you for the opportunity to serve you!

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PT: ☐DR ☐EX ☐AM ☐AN	VO:☐ TPR ☐CC ☐WC
G/WF:	